What works? What fails?

FINDINGS FROM THE NAVRONGO COMMUNITY HEALTH AND FAMILY PLANNING PROJECT

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JUST THE RIGHT AMOUNT OF COMMUNITY INVOLVEMENT

Introduction

The Navrongo experiment was launched in 1994 as a pilot project testing the mortality and fertility impact on primary health care of mobilizing untapped resources and shifting the locus of care delivery. The Project's *Zurugelu* (togetherness) dimension seeks ways of involving communities in the organization, delivery, and supervision of primary health care; the Ministry of Health (MOH) outreach dimension seeks ways of moving health services from Level B Clinics to clients' doorsteps. Based on CHFP results, this note assesses community-based strategies that worked and some that failed.

Community durbar

What works?

Community participation. While "community participation" is frequently deemed central to health policy, how to translate this concept into practical terms at the district level is often unclear. The CHFP addresses this knowledge gap by providing viable ways to develop community participation. Early in the CHFP pilot phase, it became evident that communities will donate labor towards constructing health facilities, known as "Community Health Compounds (CHC)." This interest is based on the widespread concern expressed in durbars that communities do not have access to health care. That primary health care (PHC) needs are not adequately addressed by subdistrict level clinical care alone places immediate demands on the CHFP project. This community emphasis on clinical care sustains both interest in developing CHC and accountability of the health care system to those whom it serves. In building the CHC programme, the CHFP invoked institutions of chieftaincy, lineage, and social networks to provide support for services, supervision for volunteers, community health education, and family planning themes that nurses could continue to promote. CHC have since become central to the success of the CHFP.

Community Health Compound (CHC)

CHC. Community leaders can be mobilized in support of PHC and family planning services. The process of community mobilisation builds male involvement and reduces the social tensions brought forth by the promotion of reproductive health care. Community leadership can reinforce MOH supervision.

Community-based services. It is possible to relocate nurses to CHC. Community-based paramedical care greatly increases the volume of services, improves immunization coverage, and expands the range and quality of reproductive health and ambulatory care. The strong preference for injectable contraception is addressed by doorstep- and CHC-based paramedical services. If conveniently accessible nursing services are combined with community mobilisation, health care and immunization coverage will improve, and family planning practice will increase.

What fails?

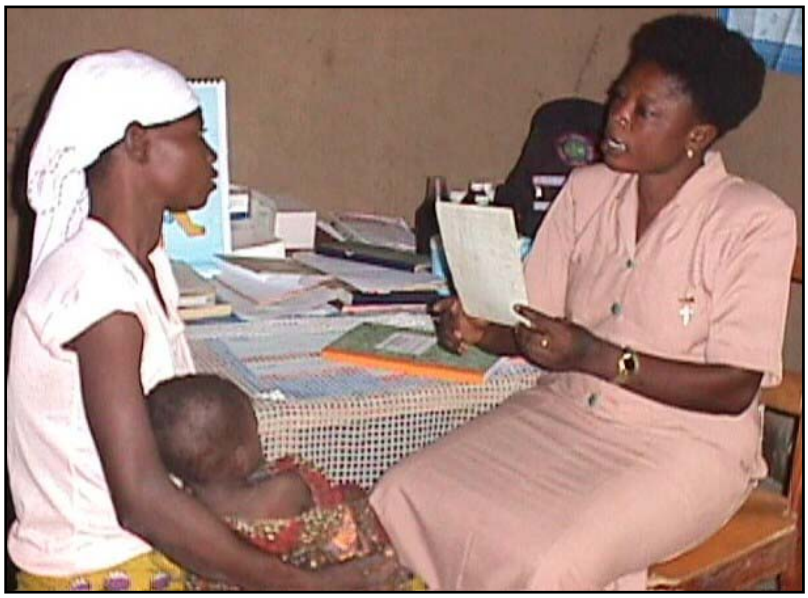
Community participation. A community mobilisation strategy that is entirely dependent on community resources is often fraught with delays. Alternatively, a community outreach programme that is externally supported can induce community conflict or apathy. Small, external resources are therefore needed as incentives for community action rather than as replacements for it. In Navrongo, communities that were provided with District Assembly support for iron sheets or other CHC construction materials were much quicker to implement the programme than those that were either totally deprived of or completely supported by external resources.

A Yezura Zenna (YZ) providing doorstep services

Community volunteers. The Navrongo project employed volunteer workers known as Yezura Zenna (YZ)—young men and women committed to improving the standards of health and well being in their community. Cells testing community health mobilisation show that community outreach alone (without resident nurse service support) has no impact on fertility or mortality. In fact, the Bamako approach may divert parental health seeking behavior from relatively costly, but effective, paramedical services to inexpensive and convenient, but ineffective, volunteer-provided services. This issue is unresolved, however, and further research is needed before definitive conclusion can be drawn. Nevertheless, findings suggest that community participation and volunteerism should be directed towards health promotion and service system support, but the provision of treatment and care should be left to trained MOH paramedics.

MOH community-based services. Doorstep family planning services had an impact on fertility only in cells of the experiment where community mobilisation was developed. Community-based delivery will fail unless traditional leaders, lineage heads, and men are mobilized to support the programme. Successful community mobilisation empowers women to exert their reproductive preferences. Failure to mobilize the community fatally weakens MOH outreach. Involving leaders, however, creates a mechanism for male involvement.

Perinatal health and neonatal survival. The Navrongo experiment has yet to demonstrate an impact on mortality in the first month of life. There is a need to test feasible means of providing emergency obstetric care in settings where access to delivery services is constrained by the absence of communication, transportation, or ambulatory care.



Community Health Officer (CHO)

Conclusion

Appropriate community involvement is complexly determined, and must be carefully equilibrated, accounting for programmatic, MOH, community nurse, community male and volunteer roles.

Send questions or comments to: What works? What fails?
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This series has been launched to share experiences with people in Ghana and elsewhere around the world about what has worked and what has failed in an experiment to make primary health care widely accessible to rural people. The Kassena-Nankana community, whose active participation made *The Navrongo Experiment* possible, is hereby duly acknowledged. This publication was made possible through support provided by the Office of Population, Bureau for Global Programs, Field Support & Research, U.S. Agency for International Development, under the terms of Award No. HRN-A-00-99-00010. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development. Additional support was provided by a grant to the Population Council from the Bill and Melinda Gates Foundation.